UCAF 2.0

Gulf Union Cooperative Insurance Company Unified Claim & Pre-Authorization Status Summary

To be completed & ID verified by the reception/nurse:

Provider Name : AL DAWAA MEDICAL SERVICES CO. LTD.
Insurance Compnay : Gulf Union Cooperative Insurance Company
TPA Company Name: IMCM
Patient File Number : 1 Dept : General
Single (✓) Married ( ) Plan Type (BRONZE)
Date of Visit : 06-NOV-2019 00:00:00
New visit (✓) | Follow Up ( ) | Refill( ) | Walk In( ) | Referral ( )

Print/fill in clear letters or emboss card:

Insured Name : YOUSEF HUSSAIN ABDULLAH AL SAEED
ID Card No. : 1757804 Sex : MALE AGE :29 Y
Policy Holder : HUSSAIN ALI AL ALI HOSPITAL Policy No : 129000003
Expiry Date : 11-OCT-2020 Class : BRONZE
Approval : 500

To be completed by the Attending PHYSICIAN : Please tick ( )

Inpatient ( ) Outpatient(✓) | Emergency Case ( ) | Emergency Care Level 1( ) 2 ( ) 3 ( )

BP: Pulse : bpm Temp : °C Weight : Kg Height: cm R.R: Duration of Illness : 90 (Days)

Chief Complaint And Main Symptoms DIABETES MILLITUS
Significant Sings: DIABETES
Other Conditions
Diagnosis Non-insulin-dependent diabetes mellitus with coma, not stated as uncontrolled
Principal Code :E11.00 2nd Code : 3rd Code : 4th Code :

Please tick (✓) where appropriate

Chronic ( ) Congenital ( ) RTA ( ) Work Related( ) Vaccination ( ) Check-Up ( )
Psychiatric ( ) Infertility ( ) Pregnancy ( ) Indicate LMP :

Suggestive line(s) of management : Kindly, enumerate the recommended investigations, and/or procedures For outpatient approvals only:

			Requested		Status		
CODE	Description/Service	Type	Quantity	Cost	Status	Quantity	Cost
1	JANUMET 50/1000MG 56 TABLETS		3	1,368.00	Approved	3	1,368.00

Providers Approval/Coding staff must review/code recommended service(s) and allocate cost and complete the following:

Completed /Code By..... Signture..... Date.....

			Requested		Status		
CODE	Medication Name (Generic Name)	Type	Quantity	Cost	Status	Quantity	Cost

In Case managment form (CMF 1.0) Included Yes ( ) No ( )
Please specify possible line of managment when applicable:.....
Estimated length of stay: Days Expected date of admission: 06/11/2019

I hereby certify that ALL information mentioned are correct and that the medical services shown on this form were medically indicate and necessary for the managment of this case.

Physician Signture Stamp Date
....

I hereby certify that ALL stetements and information provided concerning patient identification and present illness or injury are TRUE.
Name (and relationship (if guardian):----------
Signture(*)..... Date.....

For Insurance Company Use Only: Approval Status APPROVED Approved No: 779246 Approval Validity: 30 Days

Comments (include approved days/services if different from the requested).

1 H - Submited for Approval - ALDAWA09
2 H - THIS REQUEST FOR MEDICAL REFILL FOR CHRONIC MEDICATIONS – PRESCRIPTION DATE IS 31-10-2019 FOR 3 MONTHS AL-DAWAA PHRAMCY BRANCH NO (P0281) - ALDAWA09
3 GU - This Request is APPROVED - GKUTBI

Approved/Disapproved By GKUTBI 487 Signature Entry Date & Time 06-NOV-2019 12:55:40 Approved Date 06-NOV-2019 13:18:19

(*) This is applicable only in case of manual UCAF

GUCIC Confirms the coverage of member's treatment specified in the requested filed based on the limited information provided during pre-approval. GUCIC reserve rights to fully or partially decline payment any for following reasons

1. If details at the time of claim submission differ from those disclosed at the time of pre-approval.
2. If the line of treatment or services is not according to internationally recognized medical slandered and MOH approved practice
3. If in case of forgery

All the above approved cases will be considered upon submission of the claim with the original signed claim form, invoices, medical report, IQAMA copy and signed patient declaration form for in patient surgeries and procedure etc.